INSTITUTE FOR ADVANCED PSYCHIATRY

Transcranial Magnetic Stimulation & Brain Music Therapy

KETAMINE TREATMENT CONSENT

Date:______________ Patient Name:___________________________________ Date of Birth:________________

Please Initial Each Statement:

________ Ketamine is an anesthetic agent. At subanesthetic doses (doses bellow the amount necessary for general anesthesia), Ketamine is useful in the treatment of Major Depression.

________ Use of Ketamine for the treatment of Major Depression is considered investigational by the Food and Drug Administration.

________ According to the literature, Ketamine is efficient in about 70% of the cases and the effects typically last for about 2 weeks. Longer or shorter duration of action is possible.

________ Ketamine treatment is currently limited to a maximum of 6 months.

________ Potential side effects from ketamine include dizziness, bad dreams, perceptual disturbances, confusion, elevations in blood pressure, euphoria, dizziness, increased libido and nausea. These side effects mostly disappear 80 minutes from infusion and ketamine infusion is well tolerated.

________ There is a small but not zero risk of habituation with Ketamine.

________ I have been explained thoroughly about the use of Ketamine for Major Depression and I had the opportunity to ask all the relevant questions I felt necessary.

________ I voluntarily request Dr Ghelber and her team at The Institute for Advanced Psychiatry to administer Ketamine for the treatment of my condition.

________ I understand that I can revoke this consent at any time including during the infusion.

________ I understand that the duration of the infusion will be approximately one hour and I understand that it will be necessary for me to stay in the office for a while after the infusion ends, typically a few more hours.

Patient Signature:____ Date:____________________

Witness Signature:________________________________ Name:______________________ Date:_____________

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